May 21, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of AARP's over 37 million members and the millions of Americans with Medicare, thank you for holding a hearing to examine Medicare beneficiary cost-sharing. Medicare continues to play a vital role in the health and financial security of older Americans. We have long recognized the need to strengthen and improve the program and appreciate the Committee is considering ways to do so.

This hearing focuses on changes to three particular areas of cost-sharing: expanding income-relating of Part B and Part D premiums; increasing the Part B deductible; and adding copays to home health services. Modifying any part of the Medicare cost-sharing structure could have a significant impact on beneficiaries. We are concerned that a discussion of beneficiary cost-sharing focused on reducing Medicare expenditures ignores the underlying issue of high health care costs system-wide. As Congress considers various proposals, we urge you to examine all the potential ramifications on beneficiary out-of-pocket spending, access to needed care, and total costs to the health care system.

Background

Medicare is the major pillar of health security for older Americans and people with disabilities. Yet, the program provides fewer benefits than most employer-sponsored insurance plans and only covers about half of beneficiaries' total health care costs. There are notable gaps in current Medicare benefits, including the lack of a catastrophic cap and coverage for certain common health benefits, such as dental, vision, and hearing. In recent years, the creation of the Medicare Part D drug benefit in 2006 and the phasing out of the coverage gap, or "doughnut hole", in Part D – as required by the Affordable Care Act – have been major improvements. Yet, even with these improvements, out-of-pocket costs still remain a great burden for many Medicare beneficiaries. At least 50 percent of Medicare beneficiaries have incomes of less than $22,500 and spend nearly 17 percent of income on health care. Ten percent of beneficiaries spend over $7,800 on health care costs.[1] Additionally, out-of-pocket spending is higher for older and poorer beneficiaries: spending increases to over 20 percent of their income on health care.

Without an out-of-pocket cap, the traditional Medicare program currently leaves beneficiaries at risk for significant cost-sharing if they become seriously ill or need to manage chronic health

[1] C Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care", AARP Public Policy Institute, Washington, DC, May 2012. Includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf

conditions. No other public or private health insurance plan imposes the same level of risk on their participants: these plans generally limit the amount of cost-sharing that participants have to pay in a year or a lifetime. As a consequence, most Medicare beneficiaries rely upon other supplemental insurance to avoid the potential risk of significant out-of-pocket costs (e.g. employer-provided retiree health and Medigap) or rely on Medicaid. Not all beneficiaries have supplemental insurance coverage, however. About 4 million beneficiaries (8%) have no additional coverage, and potentially face significant health care expenses should they become seriously ill.

In exploring any changes to Medicare cost-sharing, AARP believes it is essential to look at any proposed changes from the perspective of beneficiaries, not just from the perspective of a budget score. Most beneficiaries already struggle to make ends meet, and they are particularly sensitive to the high cost of health care and prescription drugs. An examination of Medicare cost-sharing must take into account the economic status of seniors, as well as evaluate how benefit changes will interact with other potential changes to the Medicare program.

Income-Relating of Premiums

As you know, premiums for Part B & D are currently income-related, whereas individuals and couples earning more than $85,000 and $170,000, respectively, pay a higher rate. The premium amount is scaled higher over three subsequent income tiers. Approximately 5 percent of beneficiaries are subject to the higher-income premiums for Part B. Approximately 3 percent of beneficiaries are subject to the higher income premiums for Part D.

Various proposals have considered revising the existing income-relating structure. In general, proposals tend to increase the share of Medicare costs paid by the beneficiary, lower the threshold for those subject to income-relating, or some combination of the two. No matter how it is implemented, though, expanding income-relating directly shifts costs onto beneficiaries without addressing the high cost of health care.

Moreover, forcing higher-income beneficiaries to pay even greater premiums could drive people away from Medicare, which would be detrimental to the program. Higher income beneficiaries have already paid more into the system in the form of higher payroll taxes – all wage income is subject to the payroll tax – as well as higher income and Social Security taxes. Given higher income and payroll tax payments and current income related premiums, asking higher-income individuals to pay even more for their Medicare is both a work and saving disincentive. Also, when determining who is subject to the income-related premium, the Medicare program relies on the beneficiary's tax return from the prior year (which reports income made from the year before). Thus, new retirees (whose income is likely to have dropped precipitously from their working years) would be subject to a higher income-related premium based on their previous wages, not their current financial situation. On average, Medicare spending goes down as income goes up. If the beneficiaries in the highest income group are asked to pay an even greater share of their Medicare premium, they could decide not to enroll in Medicare and seek alternative sources of insurance. This would worsen the Medicare risk pool, leaving more costly beneficiaries in the Medicare program, raising costs for everyone else.

Part B Deductible

In 2013, the deductible for Part B (medical insurance, including physician visits) services is $147. As noted above, the typical Medicare beneficiary lives on a modest income and already spends a significant portion of it on health care expenses. Raising the deductible amount, either through periodic increases or combining it with the Part A deductible, would increase beneficiaries' out-of-pocket costs, even for those who could least afford it.

Increasing up-front costs for beneficiaries creates a barrier to seeking care – discouraging both necessary and unnecessary care. Asking beneficiaries to pay more out-of-pocket will lead to less access to the health care system. While it may lower utilization rates, delaying or neglecting preventative and routine care will result in even greater costs to the system later. Any discussion about changing Medicare deductibles must include an analysis of the impact on access to care, particularly for lower-income beneficiaries.

Home Health Copays

In 2011, approximately 3.4 million beneficiaries used Medicare home health services, for which there is no copay. Congress eliminated cost-sharing for Medicare home health care decades ago so that more beneficiaries who need care would get it at home and not have to turn to a more expensive hospital or skilled nursing facility.

Despite the financial burden many beneficiaries already face for health care costs, proposals to add home health copays or cost-sharing range from about $100 to $600 per 60 day episode (this includes proposals to establish a uniform 20 percent coinsurance in Medicare). Like other beneficiary cost-sharing proposals, adding copays can have the effect of discouraging necessary, as well as unnecessary, care. And as with other cost-sharing proposals, discouraging necessary care can have the effect of reducing health care outcomes and increasing total Medicare costs down the road.

Furthermore, Medicare beneficiaries receiving Medicare home health care are likely to be older and have lower–incomes, and thus least able to afford the added costs. Those asked to incur these higher proposed copays are also likely to already face high health costs, including costs from a recent hospitalization or nursing home stay.

Costs would also be shifted to other payers, such as States and private employers. State and federal Medicaid spending would increase, since Medicaid would pay in many cases for the copays of individuals dually eligible for Medicare and Medicaid. Some state officials have raised concerns about added copays, since these increased costs would increase cost burdens for states already under tight fiscal constraints. Similarly, employer costs for supplemental retiree coverage would also increase, as supplemental plans would pay the cost sharing amounts previously covered by Medicare. Indeed, the previous experience with a Medicare home health copay led Congress to ultimately repeal it, due to the burden it placed on seniors and the fact that services were shifted to more costly settings.

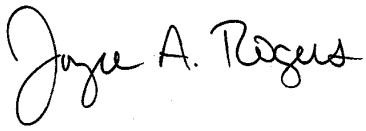
Conclusion

Any redesign of Medicare cost-sharing will have a significant impact on beneficiaries, and will affect various groups of Medicare beneficiaries differently. The impact will ultimately depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services, home health, or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

Finally, Congress must consider Medicare benefit redesign in the context of broader reforms to the health care system. If redesigning the Medicare benefit package simply results in more cost-shifting to beneficiaries and other payers, it will do little or nothing to reduce overall health care spending. Indeed, it may increase total health care costs. In fact, Medicare spending growth is already moderating. According to the Congressional Budget Office, from 2007 to 2012, Medicare spending growth has averaged only 1.9 percent per year. As a result, in May 2013, the CBO reduced its estimate of projected 2020 Medicare spending by $138 billion from its estimate in 2010. Moreover, Medicare spending increased only 0.4 percent per beneficiary in 2012, substantially below the growth in GDP of 3.4 percent per capita. With the rate of Medicare growth stabilizing, focusing solely on Medicare benefit cuts or cost-shifting to achieve budget savings misses the larger need to build on reducing health care costs throughout the health care system.

Again, we thank you for holding a hearing to explore Medicare cost-sharing. Medicare reform should be done cautiously and deliberatively, in an effort to avoid negatively impacting the beneficiaries who rely on the program for their health and financial security. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,



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